MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 28, 2004
9:32 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
SHEILA P. BURKE
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
CAROL RAPHAEL
WILLIAM J. SCANLON, Ph.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Public Comment

DR. THOR: My name is Bill Thor, I'm a practicing radiologist in North Carolina and immediate past president of the American College of Radiology.

We'd like to applaud the Commission's efforts to control inappropriate utilization of imaging services while preserving quality. And we'd like to comment that the goal for Medicare would be to promote that the right test, based on appropriate clinical indications, be done that influence clinical care decisionmaking, but it be performed in a safe high-quality facility by trained professionals, and interpreted by physicians with documentable education, training and experience.

I think that bullets one, two, four and six in the options in your brief do address exactly that goal. My concern with option five is that the concept of tiered providers leaves, in fact, providers who are still providing substandard or subquality imaging services. In fact, imaging procedures that are misinterpreted generate more health care costs. They generate repeat procedures, they generate potentially surgery that's unnecessary. So I think the concept of privileging makes sense. The concept of developing tiers, leaving providers doing it that aren't appropriately qualified, would be a mistake.

Secondly, the worst outcome for beneficiaries would be that the changes be made via across-the-board reimbursement cuts or inappropriate coding edits that result in decreased quality of current imaging and decreased research and development in the field.

The increased imaging realized may result in a decrease in the total cost of episode of care, and there's been a lot of discussion about profiling episodes. Examples are abdominal trauma where now exploratory laparotomy is oftentimes precluded by CT examinations that demonstrate no significant injury.

The vast majority of imaging services performed by radiologists is done based on referral from another physician or health care provider, so that the 47 or 48 percent that you described and Dr. Milstein addressed, that in fact it's not the radiologist who is responsible for the generation of that test.

And that multiple exam efficiencies we were talking about edits with the potential for reduced reduction, may make sense in the technical component side. But in fact, in the professional component side, when I'm interpreting a CT of the abdomen and pelvis, if I find something in the pelvis, it's going to force me to go back and re-examine the abdomen. In fact, in the professional component, there's really no efficiency in doing concurrent exams on the same patient. Many radiology information systems actually require that you bar code in a whole separate accession number, in fact, to go ahead and dictate that second

exam.

So again, just addressing those specific points. Thank you.

DR. GUCCIONE: Thank you. I'm Dr. Andrew Guccione, Senior Vice President of the Division of Practice and Research of the American Physical Therapy Association. On behalf of the Association and its 66,000 members, I want to thank you for looking at the issue of direct access this afternoon.

As you know, Congress intended MedPAC to look at the issue. And in August we provided you with this report, which we believe supports implementation of policy. In that report we did provide you with six key emphases which have to do with timely access, the ability for physical therapists without referral to provide safe and effective care, to provide care that's cost-effective, that will improve the quality of life, enhance collaboration among providers, and improve patient choice.

Several national associations have supported our request and we hope in your deliberations today that you will recommend to Medicare a change in implementation of policy and would appreciate the opportunity to make some comments again after we hear the staff report.

Thank you for your attention.

MR. HACKBARTH: Just for future reference, for you and everybody else who's a regular participant in this, I asked that you confine your comments in the public comment period to things that we've discussed in the preceding session. Among other concerns I have as I don't want everybody to come in and say I'm going to do my MedPAC thing for the week right at lunchtime of the first day and we've got a queue going out into the hall.

And it's also more useful to the commissioners if you do it connected to the presentation from the staff. Thank you for adhering to that request.

MS. MELMAN: Hi, I'm Diane Melman and I'm representing the American Society of Echocardiography and I want to speak to the diagnostic imaging issue.

There are a number of aspects of the discussion that are troublesome. Just as a preliminary matter, the statistics that have been put on the board regarding the growth in diagnostic imaging do have a problem with them insofar as they don't take into account shifts in sites of service which has two effects. One is to somewhat elevate the perceived utilization growth which is certainly problematic and should be looked at. But I think that we do need accurate statistics on it.

The second impact of that particular anomaly with the data is that it overestimates the extent to which diagnostic imaging is performed by non-radiologists.

I think that there was a question raised about what is the problem in Medicare? What's going on in the Medicare program? Where is the growth in the Medicare program?

I think that it's important to note that the aspect that two or three modalities that have experienced the largest growth in Medicare are CT and MRI, which happen to be also the more expensive of technologies and therefore have a bigger impact on

the Medicare budget. Those are technologies that again are dominated to a very large extent by radiologists. More than 90 percent of CTs and about that of MRIs are actually performed by radiologists.

I can speak to the cardiology services, as well. The most recent statistics on nuclear cardiology and echocardiography, taking out of the site of service problem that infects some of the MedPAC data, shows about a 6 percent increase from 2000 to 2003 in those modalities, which is higher certainly than the 3 percent overall average, but certainly is not in the double digits.

I also want to address this issue of who's referring for what. I think that there is an oversimplification here to say that radiologists do not refer. That's true and not true. Certainly, under the Medicare program radiologists are required to have a written order by a physician. However, what often happens is that the radiologist will then write back to the physician and say we need X, Y and Z test, in addition to what's been ordered. And of course, in this malpractice environment, that's what happens.

It is also true that radiologists, to a very large extent, do own their own equipment and benefit from technical component payments. So I think that the issue is much more complicated than it would appear at first. it is extremely politically divisive and there have been and continue to be substantial issues about specialty designations.

In echocardiography, in particular, that is a service that actually started out as a war between the radiologists and the cardiologists. It has since become very much a cardiology procedure and very much a part of the practice of cardiology. So I would caution the staff and the Commission not to adopt specialty specific designations in the things that it does. Most of the guidelines, the training guidelines of the American College of Cardiology, for example, are not specialty specific. They have to do with training and education. And I would caution the MedPAC commissioners and staff to also stay away from specialty specific designations and move towards training and education.

Thank you.

MS. MIROFF: I'm Julie Miroff and I'm here with Dale Seer, Tammy Sloper, and Ann Jones on behalf of the Coalition for Quality in Ultrasound.

The Coalition for Quality in Ultrasound is an alliance of 14 leading diagnostic medical ultrasound societies and organizations. They've all come together based on advocating for the implementation of standards that would require the credentialing of technical component personnel and/or the accreditation of the facilities where all ultrasound services are provided.

We greatly appreciated today's report by Ariel Winter that examined some of utilization issues in imaging services. We believe that accreditation and/or credentialing are proven means

of really ensuring that care of the highest quality is presented to Medicare beneficiaries and that the Medicare program is not subjected to inappropriate utilization that, of course, raises the cost of these services.

We submitted comments to MedPAC in September that really established our main arguments supporting these standards. First, we discussed that there is a consensus not only among the relevant medical societies but also a growing consensus among the Medicare carriers to implement these standards to ensure that Medicare beneficiaries receive and that Medicare only pays for the care of the highest quality.

Also, we discussed the threat or the risk to Medicare beneficiaries when these services are provided by uncredentialled personnel or an unaccredited facility. We also examined, as Ariel Winter had pointed out, that Medicare does frequently use accreditation and/or credentialing in its program as a means of ensuring appropriate utilization of services.

An example that was raised today is with the IDTF component that really reinforced the standards and we'd like to see them implemented more widely in the Medicare program. We've also documented the availability of credentialled personnel and accredited facilities in the area.

And we have these three members of the CQU who wanted to just briefly share their expertise with these accreditation and credentialing standards. We appreciate again your consideration of these issues in ensuring that Medicare is a prudent purchaser and ensuring the highest quality of care for Medicare beneficiaries.

MR. HACKBARTH: Unfortunately, we don't have time to go through multiple additional people. We do need to get to lunch so we can convene our outside panel promptly on time.

Is there anybody else in the queue on a separate subject? If not, I apologize but we are tightly constrained.

And actually, I think the most efficient -- I'll repeat something I've said multiple times before, the most efficient way to communicate with commissioners -- there are actually a couple. One, of course, is through the staff who make a concerted effort to reach out to various groups and I gather including yours. A second is to communicate with the commissioners individually via a letter so that people have the time to give it the thoughtful consideration that it is due.

This is, frankly, a last resort. This is probably the least effective way to communicate with commissioners just because we have such limited time together as commissioners. We cannot have an extended public comment.

So please avail yourselves of all of the available channels. And we are going to convene again at 1:15 p.m., when we have our outside panel. Thanks.

[Whereupon, at 12:26 p.m., the meeting was recessed, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION [1:20 p.m.]

MR. HACKBARTH: We are going to begin this afternoon with a panel on clinical IT. Chantal, are you going to do the introductions?

DR. WORZALA: Good afternoon. I'm going to very briefly introduce our panel. I want to make sure they have maximum time both for their presentations and your discussion afterward. I know I cannot do justice to their qualifications in a minute or so and I do encourage you to refer to their bios which we put in your binder.

Karen, Chad and I worked together to put this panel on, and it's a continuation of our work in IT which we started last spring and plan to continue in this report cycle. You all had expressed an interest in hearing from people who had successfully implemented IT, so we sought out individuals who had successfully navigated this IT maze in three different settings.

Our first speaker will by Dr. Omura. He is a primary care physician from Grand Junction, Colorado. He and his partners were really pioneers, choosing to install an EMR more than 10 years ago. He will talk about using an EHR in a small practice environment and look at its usefulness both for quality improvement and also for performance reporting.

Our second speaker is Dr. James Walker, who is the chief medical information officer at Geisinger Health System which is located in central Pennsylvania. We've asked him to describe for you the many EHR and IT initiatives that they have going, and asked him to speak specifically about their patient EHR.

Then our third speaker, Dr. Clement McDonald, is director of the Regenstrief Institute, which is in Indianapolis. He will be discussing their regional health information network which facilitates sharing of information across providers and has been the premier network in the country.

So I'll turn it over to you and thank you. We'll start with Dr. Omura.